Patient Information

Patient Name: _____
Title Last, First MI (Preferred Name)

Gender: _____ Family Status: _____ Birth Date: _____

Phone (Cell): _____ (Home): _____ (Work): _____ Best time to call: _____

Email: _____ Preferred method of contact: ☐ Text Message ☐ E-Mail ☐ Phone

Address: _____
Street Apartment #

_____
City Province Postal Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Latex Allergy
- ☐ Penicillin Allergy

Other Allergies:
_____
_____

- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Pressure:
  - ☐ High or ☐ Low
- ☐ Bone Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Endocrine Disorder
- ☐ Epilepsy
- ☐ Emotional Problems/ Depression
- ☐ Excessive Bleeding
- ☐ Fainting/ Dizziness
- ☐ Head/Face Injuries
- ☐ Heart Disease
- ☐ Hepatitis: ☐A ☐B ☐C
- ☐ Hormonal Disorder
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Illness
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐
- ☐ Sinus Problems
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid
- ☐ Tuberculosis

- Are you presently taking any drug or medication? ☐ Yes ☐ No
  If yes, please list medications being taken:

  Drug: _____ Reason: _____
  Drug: _____ Reason: _____
  Drug: _____ Reason: _____

- Have you ever had complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____

- Do you require or have ever required premedication prior to dental visits? ☐ Yes ☐ No
  If yes, please explain: _____

- Have you had any serious illness or been admitted to hospital during the past 2 years? ☐ Yes ☐ No
  If yes, please explain: _____

- Are you under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____

- Name of Physician: _____ Phone: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian Day/Month/Year

Dental Information

Name of previous dentist: _____ Date of last dental visit: _____City: _____
Have you had any dental x rays taken in the last year? ☐ Yes ☐ No
Have you had complications from local anesthetic? ☐ Yes ☐ No
If yes, please explain: _____
Do you clench or grind your teeth at night? ☐ Yes ☐ No
Does your jaw ever make clicking or popping sounds? ☐ Yes ☐ No
Are any of your teeth sensitive to: ☐ Cold ☐ Heat ☐ Sweets ☐ Biting
Please discuss any previous experiences that make you uncomfortable coming into the dental office:
_____
_____

Referral Information

Whom may we thank for referring you to our practice?
☐ Another patient ☐ Dental office ☐ Yellow Pages ☐ Online ☐ Other: _____

Name of person or office referring you to our practice: _____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment
Employer Name:_____ Occupation: _____
Address_____Phone Number:_____
Street City/Prov/Postal Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #:_____
Insured's Address: _____
Street City State Postal Code
Insured's Employer Name: _____
Address: _____
Street City State Postal Code
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____
Insurance Plan Name and Address: _____
_____

Secondary
Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #:_____
Insured's Address: _____
Street City State Postal Code
Insured's Employer Name: _____
Address: _____
Street City State Postal Code
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____
Insurance Plan Name and Address: _____

Appointment Policy

We Would like to ask for your help in providing a minimum of **TWO BUSINESS DAYS NOTICE** if for any reason you will be unable to keep your appointment.
This consideration will allow us to accommodate those patients that may be waiting for an appointment.
If you are unable to provide notice there will be a $75 short notice cancellation fee.
For your convenience, we will continue to call or email you prior to your appointment to remind you of your visit.
I _____have read & understand the above policy. Date: _____Signature: _____
Name (First/Last) (day/month/year) (Signature of patient)

NUERA DENTAL CENTER

201 13th Avenue SE
Calgary, Alberta T2G – 1Z8

Dental Office Personal Information Consent Form

We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use, and disclose. In addition to the circumstances described in this form, we also collect, use, and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home addresses, work addresses, home telephone numbers, work telephone numbers, and e-mail addresses. Contact information is collected and used for the following purposes:

- To open, and update patient files
- To invoice patients for dental services, to process credit card payments, or in collect unpaid accounts
- To process claims for payment or reimbursement from third-party health benefit providers, and insurance companies
- To send reminders to patients concerning the need for further dental examination or treatment, and to send patients informational material about our dental practice

Contact information is disclosed to third party health benefit providers, and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patient's behalf.
Financial information may be collected in order to make arrangements for the payment of dental services.

We collect information from our patients about their health history, their family health history, physical condition, and dental treatments. Patients' medical information is collect, and used for the purpose of diagnosing conditions, and providing dental treatment:

Patients' Medical information is disclosed:

- To third party health benefit providers, and insurance companies where the patient has submitted a claim for reimbursement or payment of all of our part of the cost of dental treatment or has asked us to submit a claim on the patients' behalf
- To other dentists, and dental specialists, where we are seeking a second opinion, and the patient has consented to us obtaining the second opinion
- To other dentists, and dental specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment
- To other health care professionals such as physicians if the patient, with their consent, has been referred by us to the other health care professionals for either a second opinion or treatment

If we are ever considering selling all or part of our dental practice, qualified potential purchasers may be granted access as part of the due diligence process to patient information in order to verify information important to the potential sale. If this occurs, we will take steps to ensure that the prospective purchaser safeguards all personal information.

Dentists are regulated by the Alberta Dental Association, and College, which may inspect our records, and interview our staff as part of its regulatory activities in the public interest.

I consent to the collection, use, and disclosure of my personal information as set out above.

_____	_____	_____
Date	Print Name	Signature

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Patient Consent and Certification Form

Consent to Treatment

I authorize Dr. Chin, or his qualified staff whom he designates, to perform advisable treatment, consultations, and/or radiographs as agreed upon throughout the course of treatment. If, during the course of procedures differ from what was originally contemplated, you will be provided with additional explanation of procedures, and expenses involved. I also acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained. I understand that the laws of the Province of Alberta will govern this Consent to Treatment Form.

Consent to Anaesthetic

I consent to the administration of local anesthetic as indicated, and understand that in extremely rare circumstances paraesthesia (numbness) may result from the administration of local anesthetic.

Certification of Medical History

I, the undersigned, certify that I have provided an accurate, and complete medical history, and have for knowingly omitted any information. I have had the opportunity to ask questions, and receive answers to any questions about my medical history. It is my responsibility to inform this office of any changes in my medical status.

Emergency Care only Consent

I authorize the dentist to perform procedures, and treatment, and/or consultation with or without x-rays as may be necessary. I also understand this treatment is for my immediate problem, and should not be regarded as a complete examination with resulting treatment. I understand that no guarantee or assurances has been made to me as to the results that may be obtained.

Responsibility of Fees for Services Rendered

I assume responsibility for fees associated with all these service, and authorize the release of any information regarding my diagnosis or treatment to another dentist. I understand that third party benefits may be different that discussed by our team, as they are not under the control of this office. With the passing of the Privacy Act in Alberta, insurance carriers are only to release information to the subscriber. We will assist you in claims submissions only when you have provided us with all your insurance information. I also acknowledge that I am responsible for the payment of all services to me by this office regardless of what my insurance may or may not cover.

Patient (Parent/Guardian) Signature_____ Date (d)__(m)__(y)__

I AUTHORIZE ELECTRONIC SUBMISSION OF MY DENTAL CLAIM FORMS
(Initial) _____